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POLLUTION OF KANSAS STREAMS.

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Kansas is prospering and growing in population. Density of population carries with it the penalty of increased morbidity and death. A source of danger in a community is often an impure and unwholesome water supply.

Water is man's greatest necessity. Water comes to us from snow and rain, and is collected from nature in springs or underground sources, from ponds, lakes and rivers. The location of cities on streams, lakes and the coasts is a matter of convenience and commerce. Then such a body of water is made to serve as water-supply and a vehicle for refuse of factories and urban life. Surface water is used for commerce, fishing and recreation, industrial, domestic and sanitary purposes.

The requisite of a water for commerce is that it offer no obstruction to navigation, and such a water is in this sense under control of the Federal Government. Fish will not live in streams when the water is befouled with refuse, or rendered acid in reaction. Swimming, boating and park attractions demand that a body of water be clear and free from noxious odors. Industry requires an enormous amount of water, and this of certain qualities. For example, large amounts of water are required in the manufacture of paper, some mills requiring as high as 1600 pounds of water for every pound of paper made. Manufacturers before locating a factory now study the quality of water as well as the source and extent of supply.

An iron-bearing water cannot serve in bleaching without purification, and tanning calls for water free from calcium carbonate. Corrosive water forms scales in boilers for steam-making, and here the quality of water reckons in the amount of steam raised, fuel consumed and the life of the boiler, not to mention the

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toll of human life when boilers blister and crack, causing explosions from overheating. The quality of water in laundering and soap manufacture is a matter of prime consideration. Hard water curdles soap and wastes much of the soap from precipitation of the fatty acids.

It is necessary that water used in the manufacture of ice answers all requirements of potable water, and distilled water is generally used, as the natural purifying powers of the freezing process cannot be relied upon to free the water from all bacteria. It is obvious that carbonating works must be extremely solicitous as to the purity of water used.

A most important and extensive use of surface water is for domestic supply. Often a city uses the same stream for water supply and a carrier of its sewage and refuse.

Most of the surface water in Kansas comes from its own snow and rainfall. The annual rainfall at the eastern border is 40 inches, and 15 inches at the western boundary. The acquired streams come from Colorado and Nebraska. The streams of Kansas flow South and east as a rule, with small affluents flowing north and west. The flow of the ground waters is generally in a south-easterly direction.

In looking at a relief map of Kansas we notice three principal water-sheds. Starting at the western border a divide runs east through Greely, Wichita and the counties on this tier, to the eastern border at the southeastern corner of Johnson county. North of this divide is the water-shed of the Kaw river, embracing almost one half of the State. South of this divide and extending from Colorado to the Eastern margins of McPherson and Harvey counties, northern and eastern lines of Butler county and eastern confines of Cowley county, is the water-shed of the Arkansas River. East and south of these divides, draining the southeastern section of the states are many smaller rivers flowing east and south into Missouri and Oklahoma. Four northeastern counties border on the Missouri river.

With increase of population a problem of pure water-supply arises in the affairs of city life. In 1908 forty five Kansas cities, containing 318,634 inhabitants drew their water supply from surface waters, while 72 cities, with 76,730 population, used water from shallow or deep wells.

The subject of garbage and sewage disposal should receive the most serious consideration. A radical change in the present method of disposing of this refuge is necessary. Rivers are now convenient, but this practice must stop, and the nuisance abated,

even with great expenditure of money.

The custom of one city passing on its sewage and garbage to the next city a few miles down stream is abhorrent in the extreme. But this has always prevailed in this country. The European countries considered this matter half a century ago, on account of increasing density of population and resulting epidemics of typhoid fever, cholera and diarrhoea.

Accordingly these countries, impelled to action by this new danger to life, adopted methods of water and sewage purification and prevention of stream pollution. In Germany in 1877 the death rate from abdominal typhoid was 46.0 per 100,000, which rate was reduced to 11.0 in 1901. In 1900 the death rate in the registration area of the United States was 35.9 per 100,000, while in the same year the rate was 11.0 in Germany and 7.0 in Switzerland. Germany reduced this rate to 7.0 in 1902, and Switzerland's rate was 5.0 in 1903. The rate in the United States fell in 1904 to 32.0. In Kansas in 1909 there were 355 deaths from typhoid fever—a rate of 21.5 per 100,000, entirely too high for this preventable disease. Kansas is not so densely populated as those states in the registration area. The etiological factors of milk, vegetables, shell-fish, flies, filth and contact in typhoid fever are not disparaged.

In this country stream pollution has been a serious menace to many cities. Albany, Lowell, Lawrence, Washington, Pittsburg, Cincinnati, Louisville and New Orleans have had their outbreaks of typhoid fever from polluted water. They have at great expense corrected the evil.

With newly discovered resources and increase of population come factories and still more population. Then come pollution and contamination of streams. Industrial pollution of streams results from conducting into a stream the wastes of such institutions as bleaching and dye works, tanneries, mines, paper mills, iron works, oil wells, distilleries and others. This pollution is sometimes a source of danger to the water supply of a city, or detrimental to the quality of water used by another factory down stream.

In 1908 Dr. Crumbine of the Kansas Board of Health and Prof. Barber of the Kansas University took 80 samples of Kaw river water from a point west of Topeka to a point near Lawrence. The water west of Topeka was found to be impure and unwholesome, and this condition was largely increased in the water east of Topeka after receiving the sewage from Topeka. The natural purification of the water in the stream before it reaches Lawrence

was found to be slight. A similar condition exists in many of the valleys of the state. It must be conceded that some streams, such as the Missouri, have a natural sand filtration from the strong currents and swirling eddies.

The consideration of stream pollution naturally divides itself into two main heads—prevention and remedy. In the line of prevention let us adopt a different system of garbage and sewage disposal. Refuse can be sorted out for a profit. Coal can be reclaimed from cinders, stannous chloride from tin cans. Metals, paper, rubber and rags can be sorted. Slops can be converted into grease and alcohol or fertilizer. Manure can be burned or hauled to the farm. Septic sewage can be treated according to character, so that after purification the effluent can be turned into a river without danger of pollution.

The object of sewage purification is to remove pathogenic bacteria and to break up organic matter. The scope of this paper only permits allusion to naming methods—as septic tanks, contact beds, trickling and sand filters, with combination of methods. For most Kansas cities the septic tank best answers all requirements. Many small towns are now constructing septic tanks.

Proper construction is important, and subsequent proper operation is just as essential, no matter which system is adopted. Many splendid plants become inefficient on account of incompetent operators or stinted appropriations by municipalities. This year the Federal Government is expending over $7000 for overhauling the efficient crematory at Ft. Leavenworth.

One community should carry on sufficient sewage purification and the next down stream should purify its water-supply. In this section of the United States the streams are very turbid and require special treatment of purification. The methods in use are sedimentation and sedimentation with mechanical filtration. Slow sand filtration is preferable but not applicable to our turbid streams. For all purposes the best method for our muddy waters is that of sedimentation and coagulation, with mechanical filtration. Water is pumped from the river into a settling basin; the water flows slowly from this and receives an amount of aluminum sulfate and milk of lime for coagulation, and passes into other settling basins, becoming clearer in each succeeding basin. The water is then pumped into a tank where after being further settled and clarified, it runs by gravity into the mechanical sand filters in the filter house. The filtered water collects in a sluice and runs into the clear water basin for final pumping into the distributing reservoir.

Industrial wastes should be treated according to chemical nature before being conducted to any natural water of the state. In Germany the authorities consider the possibility of stream pollution before granting concessions for establishing new works, or where alterations in any works are intended. Police power applies to works needing no concession for establishment.

Legislation against stream pollution must consider the rights and duties of individual riparian owners, rights and duties of municipalities and rights and duties of the public at large. Such legislation is in the hands of the different states, and these states have different laws according to varying interests, difference of natural conditions, density of population and ignorance of consesequence of pollution. However pollution in one state reaching another state and threatening its health or property rights, enables, the injured state to become a party complainant in the Supreme Court of the United States. Cities have a right to use streams flowing through them as open sewers, with liabilities for injury to adjoining property.

The great object of legislation should be to have a stream maintained in its natural condition. Then industries can safely locate, depending on the qualities of water as found before establishing. So a city, drawing its water-supply from a stream would be endangered and if another city up stream would suddenly discharge its sewage into that stream, or a paper mill might be ruined if some industry would locate in close proximity upstream and change the character of the water.

Kansas has a good water and sewage law passed in 1907 and 1909. It calls for registration of all water works and sewage plants existing at time of passage of the law. It requires all corporations or municipalities intending to construct new water works or sewage systems, or the extension of established systems, to obtain a written permit from the state Board of Health, and to furnish maps, plans and specifications of plants. The State Board of Health can order changes in the source of water-supply, manner of storage, purifications, or treatment before delivery of water for drinking purpose. Pollution of streams by sewage is forbidden, except where such system is in operation at time of passage of law.

Sewage is defined as "any substance that contains any of the waste products or other discharges from the bodies of human beings or animals, or other wastes from domestic, manufacturing or other forms of industry." The law creates the office of sanitary engineer, who investigates and reports on all matters rela-

ting to water-supply and sewerage, acting in capacity of adviser to the State Board of Health.

The law is a good one. However it should be more stringent and forbid all garbage and sewage from being conducted into any water of the state. The state Board of Health should be allowed more assistants to the State Sanitary Engineer and a larger appropriation should be made for the sanitary fund of the same board for conducting the work as efficiently and thoroughly as the progressive and prosperous people of Kansas demand. Since the passage of the Water and Sewage law the State Engineer has taken some action in 22 water supplies, and has granted permits to 47 cities for new water supplies or extensions. Since July 1, 1907, plans for between 3½ and 4 millions dollars worth of work have been submitted. About 40 sewerage permits have been granted.

The time is coming when the Federal Government should legislate against the flagrant pollution of interstate streams. This may come after the new department of Health is created. To conserve the health and the wealth of its citizens Kansas should prevent the pollution of its streams.

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STRICTURE OF THE URETHRA.

Prognosis and Treatment.

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Read before the N. E. Kansas Medical Society, Leavenworth, Kansas, Oct. 27, 1910.

The prognosis of stricture of the urethra depends on several different things: Treatment, which is probably the most important; the character of the lesion and its location; its origin, whether gonorrhoeal or traumatic. The prognosis also depends on the physicial condition of the patient and upon his ability to adapt himself to a long course of treatment where such is necessary.

As regards a matter of life and death, the prognosis of stricture is very good, being(except in neglected cases) rarely fatal. Death may occur, however, from extravasation of the urine following rupture, from urinary septicæmia, pyonephrosis, etc. The treatment may kill the patient, reflex congestion of the kidney being sometimes induced by the passage of a sound. The injudicious use of cocain, the shock upon a diseased heart or status lymphaticus may contribute to a fatal result.

Traumatic strictures contract rapidly, often in spite of most energetic efforts, while gonorrhoeal stricture do so more gradually.

Those in the pendulous portion contract slowly and are, as a rule, much more amenable to cure. Those in the perineal urethra are less liable to respond to treatment as they tend to recontract with great rapidity. The latter are also as a rule more dense than those in the anterior portion, form quicker and contract more rapidly.

The more extensive a stricture, the denser the scar and the more irregular its surface, the less chance is there of a cure.

The main object of the treatment of stricture is the enlarging of the urethra to a certain caliber and keeping it there. This is best performed by dilatation. Never cut until dilatation fails and remember that the patient is never cured unless he stays cured.

The prophylactic treatment varies. Traumatic stricture can best be avoided by prompt action at the time the injury is received. If the injury is a mild one in the pendulous portion, keep the urethra clean; do not use a catheter in these cases. If the injuries are moderately severe they represent, in a measure, slight lacerations. Here we must avoid infiltration by keeping the urethra clean, by regular catheterism every six or eight hours or by the retained catheter. Always advise the patient of the possibility of stricture. In the milder cases contraction begins about the sixth week. In both the mild and the moderately severe cases, the caliber must be maintained by sounding.

Perineal ruptures and severe injuries to the pendulous portion call for immediate external urethrotomy and suture.

The majority of strictures are, fortunately, due to gonorrhœa. Prophylactic treatment here consists in the prompt relief of the intense inflammation which accompanies an acute gonorrhœa and in cutting down the duration as low as possible. This prophylaxis is, however, but relative. No one can tell which case is going to have a stricture and which one is not. Chronic gonorrhœa favors strictures formation, so it is evident that the latter complication is best avoided by thorough and intelligent treatment of the acute cases.

The instrument best adapted to the treatment of stricture is the sound. I am sorry to say that it is more often used wrongly than rightly, and the patient harmed rather than benefitted. There are two common sources of error in the manipulation of the sound—**haste** and **force**. The man that uses a sound properly is always extremely gentle and patient. If force is employed it will, at the very least, cause a sharp inflammatory reaction which only tends to increase the amount of scar tissue and make

it more dense. It may bruise and tear the urethra and form a traumatic stricture. False passages may be produced. Not only is this most embarassing at the time but it increases the difficulty of passage at subsequent sittings. A sound, if of metal, should pass with practically no assistance other than its own weight. If there is any resistance, try a smaller size. Take your time. Ninety-nine times out of a hundred one will slip through, and when such takes place, you will find that you can usually pass one or two more of larger size. The passage of a sound is, to say the least, not the most comfortable thing that can happen to a man, but it is not necessary to make it an act of torture. Further, cut out the cocain; let your anatomy alone and let your patient tell you by his actions whether you are in the right channel or not. The man that never exercises force will succeed where others fail. Try it. Keyes says, "The maximum of effect is produced by the minimum of effort. Guyon, "The effect is due, not so much by the pressure of the sound, but to its mere contact."

Strictures at the meatus are best treated by meatotomy, the cut surfaces being kept apart by means of a strip of guaze or, as I prefer, by catching up the mucus membrane and skin on each side separately and tying with a piece of "O" or "OO" catgut.

Spasmodic stricture may often be relieved by the passage of a full-sized sound or by a hot sitz-bath. If you know the stricture to be spasmodic a few drops of a 2% solution of cocain may solve the difficulty. If very severe, a general anæsthetic may be necessary to overcome it.

Strictures of large caliber constitute the majority of cases a physician is called upon to treat, the patient complaining of a gleety discharge, and possibly, an increased frequency of micturition. They are first examined with a bulbous bougie, to locate the size and location of the lesions. This having been elicited, no further instrumentations are advisable; at that sitting. After cautioning the patient not to mind the smarting at the next urination, a few drops of a ½% solution of silver nitrate are instilled, he is given a prescription for urotropin, and told to report again in four days. Eliminate nephritis and hyperacidity by urinalysis. Study the habits of the patient. Further, the man should always be informed that, after all symptoms have disappeared (if the stricture is in the posterior urethra) the permancy of his cure will depend upon the proper passage of a sound on himself at proper intervals.

Dilatation with a conical double-taper steel sound will be

found best adapted to the majority of uncomplicated strictures of large caliber. In size it should conform to that of the bougie passed. Insert gently and remove as soon as it has entered the bladder. Nothing is gained by leaving a sound in place for five or ten minutes as is recommended by some. If this first sound has passed readily one or two of larger size may be used. The danger of false passage being produced by a sound of large caliber is very slight yet the exercising of force may set up an epididymitis, urethral fever or produce an inflammatory condition in the stricture. Until one knows his patient it is well to insist on urotropin before, cleanliness during and either silver nitrate or permanganate after sounding. After the case is known the urotropin may be dispensed with. At each subsequent visit begin with a size or two smaller than the largest used at the previous sitting and carry the dilatation as far as possible without the use of force. Twice a week, or better still every fourth day, is often enough for the passage of instruments. This does not apply to filiforms as will be shown later.

The extent to which dilatation should be carried is governed by no fixed rule. If the meatus is not congenitally small, or contracted by disease, it will be found most satisfactory as a gauge in the majority of instances. To properly guage its caliber it must be put lightly on the stretch. Overstretching, as is denoted by a white line surrounding the lips of the meatus, is not desired. There is some discomfort at first but it soon passes off, particularly if the sound is a double taper. Once stretched to the size of the normal meatus, (usually from a 27 to 32F.) a stricture will, almost invariably, be curable; the inflammation subsides and recontraction does not take place when the intervals of sounding are increased.

Occasionally the bands of scar tissue lie deep and are very elastic, contracting again as soon as bi-weekly soundings are discontinued. Here the guage of the urethra is too small and, as further dilatation of these strictures is necessary, one must either sacrifice the integrity of the meatus or resort to the Koollman dilator. These measures failing a cutting operation is called for. The dilator may also be used to an advantage in those cases where the meatus is normal but further dilatation of the stricture is necessary to prevent recontraction. If the stricture is tough and resists dilatation one of two courses is open to the physician; either resort to urethrotomy or, if the patient is willing to stand the test, put him on gr. ii doses of thiosinamine. (One dose every other day in a little wine.) Belfield, of Chicago, claims

some success with this remedy.

When a stricture in the pendulous urethra fails to recontract within a reasonable period you may feel assured that a cure has been established. When the stricture has been fully dilated and when large shreds are no longer present, unless they be from the posterior urethra, the patient may be dismissed and told to report again in two weeks. At his next visit, if no contraction has taken place he is told to report again in one month and then again in two months more if the channel is still free. If the caliber is still the same, he can be pronounced cured.

In strictures of the bulb, unless they are soft and yield readily to one or two dilatations, recontractions are bound to occur. These cases must be taught to use a full sized sound upon themselves at regular intervals,. These intervals vary from one week to one year. These patients must be made to understand that they are responsible for there future well-being.

Strictures under a 15 F. are classified as strictures of small caliber. These are best treated with soft instruments as the danger of making false passages with small metal sounds is very great. (I use the flexible bougies up to a 20 or 21 F.) Here again dilatation is the best method of treatment providing that the stricture will dilate, that the patient has the time and is inclined to go thru a long course of dilatation and providing that urethral chills following sounding are not too numerous.

When the stricture admits filiforms only, the best results may be obtained with a Banks bougie. The introduction of the filiforms is often difficult, and, as no force is to be employed, it often taxes the patience of physician and patient. If the filiform catches it may be assisted thru a narrow opening in one of several ways. 1. Withdrawal and rotation, coupling the latter with advancement. (2) Use of filiforms having their extremities bent in various shapes. (3) Filling the urethra with a bundle of filiforms, in this way plugging up all openings in the urethra and pushing gently on each in turn until one is found which slips thru. (4) Assisting the point of the filiform to pass over folds in the posterior urethra by means of a finger in the rectum. Occasionally a urethroscope may be of benefit but it rarely succeeds where other methods fail.

In exceptional cases filiforms can only be introduced after long and persevering efforts. You must then determine whether it is best to tie the filiform in, try to pass another instrument, perform a urethrotomy or what else. If the patient is up and about, the tying in of a filiform is somewhat dangerous, if he is to remain in bed, this treatment is very satisfactory. In-

termittent dilatation may be followed by retention but, as a rule, the filiform can be reintroduced on the third day followed by larger instruments. The Banks bougie, if you can introduce it, solves the problem. Don't operate unless you have to. If you decide on continued dilatation, replace the filiform on the second day with a larger instrument. Then go ahead with the intermittent treatment.

Retention is fairly common in those suffering from stricture. The patient may be enjoying, apparently, the best of health, when suddenly, after having been out on a toot, after exposure to cold, or after the passage of a small sound, he discovers that he can not pass water. In cases of retention I always try to pass the largest sound that will enter the meatus without the use of force. This failing I try a small catheter and if this brings no results (if the obstruction appears to be at the cut-off muscle) I drop in a few drops of 2% cocaine. This some times relaxes the spasm. Then, if I do not succeeed, I try a hot stiz-bath. as hot as can be born. If it is hot enough to make the patient feel faint it is more likely to act. If there is no indication of a spasmodic stricture, the cocain is not used. Banks bougie is tried. Past history, which the patient will readily give in these cases, must be taken and your treatment must conform to this. After any of the above have proven effective dilatation must be instituted.

Should all of these methods fail the bladder must either be aspirated every eight hours for a day, or, as I prefer, introduce a small No. 12 F. catheter thru the canula, remove canula and allow catheter to remain for a day or two. The flow of urine is controlled by either tying a knot in the catheter or by means of a hæmostat. I also like to irrigate the bladder with a mild solution of permangante, 1-6000. each time that the bladder is emptied. At the end of a day or two the patient is again placed in a hot sitz-bath when, if there is no flow, the stricture may be considered impassable.

No stricture is impassable as long as urine can leak thru. I may, however, be impervious to any instrument even tho' the urine flow in a steady stream. In these cases, if there is no retention one can frequently coax the stricture into admitting an instrument.

Each case must decide for itself how much persuasion is necessary before resorting to an external urethrotomy without a guide. In old cases the physician may base his opinion on what he knows of the former history of the case. If you doubt that

the patient will submit to proper treatment, once his immediate necessity is relieved, it is best to insist on an immediate perineal section. If it is the patient's first retention and if the urine has previously passed in a good sized stream it is best to adopt palliative measures as an external urethrotomy without a guide is no snap. On the other hand, if there has been previous trouble of like character and the urine has been coming in a slow stream, delay may be dangerous.

Traumatic strictures are prone to recontract, and are often made worse by sounding. Here urethrotomy is indicated. Where the scar is linear a simple perineal section will suffice. If it is annular all of the scar tissue must be removed and the perineal opening closed by suture or graft. Other resilient strictures are to be handled in a like manner.

Innodular or indurated strictures which occupy a considerable portion of the urethra do not always take kindly to dilatation. They may then be improved by simple section or, as is more often the case, by excision.

If there is a prostatitis present we have the so-called irritable stricture. Operation is the simplest mode of treatment in these cases but can often be avoided by building up the system, putting the patient on large doses of urotropin and by using flexible instead of metal instruments.

One of the most common accidents resulting from the injudicious handling of strictures, particularly where there is retention, is false passage. After such has been produced the let-alone policy should be adopted. If the patient can urinate there need be no haste. Blood will flow for a day or two, followed by the discharge of pus for a few days. In favorable cases the wound heals in two weeks. The greatest danger lies in a too sudden return to instrumentation. If there be retention it is best to tap the bladder and insert a small catheter thru the canula as mentioned above. Put the patient on urotropin, irrigate the urethra gently with some mild antiseptic and let the urethra absolutely alone for a few days. The irritation which caused the retention will probably pass off in two or three days and the patient be able to pass his urine in the normal manner. When this occurs remove the catheter. Occasionally, in passing instruments, you may run into old false passages. If so, study their location and avoid them in the future. As most false passages are made in the floor of the urethra it is best to hug the roof with the tip of the sound.

Stricture complicated by peri-urethritis is almost entirely preventable. Early incision of the foci of suppuration and intel-

ligent treatment of the stricture will obliterate the condition. A goodly proportion of these cases complain of an ague for a few days, possibly with slight local symptoms. An examination at this time will reveal a tender perineal mass, free incision of which will save the patient much discomfort or possibly his life. There is no palliative treatment for this condition. If the condition is one of simple inflammation, gentle sounding, coupled with hot sitz-baths and leeches, may cause them to break down rapidly and disappear.

If there has formed a perineal abscess, it should be opened and drained and the stricture should be cut. If large, the incision should be very free.

If there be a large infiltration numerous free incisions should be made, the entire area laid open and all necrotic tissue removed.

Stricture complicated by prostatic abscess requires section of the stricture with incision and drainage of the abscess. If acute pyelonephritis is present the kidney must be drained thru perineal section or thru a retained catheter. If these fail perform nephrotomy.

If there be a fistula present the stricture must be dilated. A simple fistula will then heal of its own accord. If the fistula is indurated and the stricture resilient or impassable all of the scar tissue must be removed and external urethrotomy performed. (This means all of the scar tissue about the fistula.) The injection of pure peroxide of hydrogen is often curative in a fistula of the penile portion of the urethra and may be of benefit in the perineal type.

Points to be remembered in the treatment of stricture:

(1) Alkalies and rest are always serviceable, especially so if complications are present.

(2) Uncomplicated, non-resilient and not too highly irritable strictures best treated by dilatation, up to 20 F. with flexible instruments, above with metal sounds.

(3) Urotropin before, asepsis during and either silver nitrate or permanganate after sounding.

(4) Dilatation rarely necessary beyond caliber of normal meatus.

(5) If stricture resists, try thiosinamine.

(6) If patient does not want to waste time or if there are complications, cut. (In very tight strictures).

(7) Internal urethrotomy for strictures in the pendulous portion, external or combined for perineal strictures.

(8) Anterior commonly curable, posterior incurable.

(9) Impassable strictures without retention usually amenable to treatment. If finally found impervious perform urethrotomy.

(10) Retention not relieved by catheter requires hot baths or hot sitz-baths, the hotter the better.

(11) If these fail, aspiration or urethrotomy, preferably the former.

(12) Traumatic strictures often preventable by prompt treatment at time of receipt of injury. Later, urethrotomy.

(13) Excision for resilient or nodular strictures.

(14) Irritable strictures seldom require incision.

(15) Acute inflammatory complications usually call for operative interference.

(16) Never cut unless dilatation fails.

(17) Last but not least, USE NO FORCE in the manipulations of metal instruments and little or none with flexible ones.

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OBSTRUCTED NASAL RESPIRATION AND DRAINAGE.

(Diagnosis and effects.)

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Read before the Golden Belt Medical Society, Junction City, Kansas.

Only within recent years have the nose and nasopharynx received much thoughtful consideration.

Formerly the nose was described as the essential organ of the sense of smell. Its most important pathology was vaguely spoken of as catarrh, the loss of smell its most disturbing sequel. The usual treatment consisted of douches, sprays and snuffs recommended by the physician or a lay person of experience, and applied by the parent or the patient. The more thorough study in the laboratory and the clinic has revealed, the fact, that the sense of smell is the least important of the nasal functions, and has demonstrated that free nasal respiration and unobstructed nasal drainage are of inestimable value in maintaining a normal condition of the body. It is to these functions of the nose we should give most thoughtful consideration.

First, Respiration.—The inspired air in its passage through a normal nose is modified to suit the need of the organ to which it is to go. Foreign bodies are removed, temperature and moisture regulated. If the air should be thus treated the condition of the nose must be adequate for such treatment. Mechanically

considered, the air must be so spread over the mucus membrane to permit of said changes. If the measurements of the nasal fossal are of such large dimensions as to permit part of the air to pass without being properly modified, or too small to admit sufficient quantity of air, abnormal conditions will develop.

Second, Drainage.—The pneumatic cavities, known as the accessory sinuses of the nose, communicate with the nasal fossæ and drain into them, the orbital secretions escape via, the nasal sinuses. The mucous membrane lining the nose pours its secretion into the nasal fossa as a canal of exit.

Other functions of the nose, olfaction, phonation, oxidation, etc., have little to do with the pathology, and need not be considered in this essay.

Kyle, in his most excellent work makes this statement; too much importance cannot be attached to obstructed nasal breathing. If long continued it produces a marked effect on the general health; especially is this true in children.

Ballinger, in his recent work puts much emphasis on this physiopathologic law. "Cavities lined with mucuos membrane are predisposed to inflammation when their drainage and ventilation are obstructed."

Clinical observations verifies the truthfulness of their statements. In nasal as in other pathology, the general practitioner is usually the first to be consulted; consequently a discussion by this society of the classification diagnosis and effects of lesions producing obstructed nasal respiration and drainage may not be untimely. The following classifications will be sufficient for the purpose of this paper.

Deformities of the bony frame work; Deflected septum; Osteoma; Spines and Crests; Myoma or Nasal polypi; Fibroma; Adenoma; Adenoids; Hypertrophied Tonsils; Hypertrophied Turburnates.

A glance at this list will, no doubt, cause most of us to realize that a diagnosis depends almost exclusively on inspection, furthermore—that the value of such inspection must depend upon the ability of the observer to make a searching examination and to determine the true nature of the objects seen. Such art and ability is not inherited but is the product of much careful study and training. Every text book describes the necessary instruments and methods for making examinations of the nose. I believe it to be a duty of every practitioner to prepare himself to make such examinations and to acquire sufficient skill to make a diagnosis.

The symptoms of nasal obstruction are much the same, no matter what the lesion, being modified by the age of the patient, the extent of the obstruction and the length of time it has existed.

Obstructed respiration is the most constant symptom, it may vary in amount from an almost imperceptable degree to complete closure of the nose and mouth breathing. Discharge from the nose or from the naso-pharynx should always arouse suspicion. If in children, it usually indicates adenoids. Frequent colds, ear-ache, etc., indicate naso-pharyngeal pathology. Absence of normal nasal resonance of the voice depends upon the amount of obstruction. The facial expression, deformity and mental condition are dependent upon extent and duration of the obstruction also the age of the patient. Physical changes due to to malnutrition resulting from obstructed breathing are too numerous to be considered in this paper.

Deformities are significant in proportion to their interference with the functions of the nose, or detraction from the facial appearance of the individual. A deflected septum should be carefully inspected, with reference to drainage, pressure and respiration. As a rule deflections in the middle turbinal region are more important because the frontal sinus and ant-ethmoid cells through their ducts and the maxillary sinus through its ostea, communicate with the middle meatus. Obstructed drainage or infection of the mucous membrane in this region may cause infection and inflammation in the mucous membrane of the sinuses just named.

Pressure on any part of the nasal mucus membrane will if continued produce pathological changes. Closure, partial or complete, of the olfactory fissure will interfere with drainage from post ethmoid cells and sphenoid antrum, said interference may cause inflammation changes in the mucous membrane and communicating cavities above. Osteoma, spines, crests, etc.; their presence must be determined by inspection. Myxoma or nasal polypus, fibroma, adenoma and other tumors found in the nasal fossa are diagnosed as in other parts of the body, by microscopic and macroscopic examination.

Hypertrophied turbinates and hypertrophied tonsils are diagnosed by inspection. Adenoids are the most common of all nasal lesions, the symptoms: obstructed breathing, discharge from the nose, hypertrophy of the lymphoid tissue in the post-pharyngeal wall, below the soft palate, and in advanced cases mouth breathing etc., are usually sufficient for a diagnosis. The use of the index finger or the pharyngeal mirror may be used to

confirm the diagnosis.

The disturbance or damage resulting from one or more of these lesions, is usually in proportion to the amount of obstruction resulting from their presence,also duration. Obstructed nasal respiration and drainage, is frequently a very potent predisposing cause in the following diseases, acute rhinitis; chronic rhinitis; hyperplastic rhinitis; hypertrophic rhinitis; inflammation of the sinuses; inflammation of eustachian tube, tympanum and mastoid, brain abscess of otitic origin; reflex neuroses and ocular troubles.

Statistics show approximately ninty-five per cent of school children having earache also have adenoids; seventy-five per cent of brain abscess are of otitic origin.

New York school statistics show that one child in every six has adenoids.

Some of the effects of obstructed nasal respiration as observed in children, the forced inspiration produces a drawing of the facial muscles, changing expression, producing deformity and lack of mental development. Probably the deformity, if excessive will be most noticeable in the narrow face, the high and irregular arched hard palate, contracted superior dental arch with teeth, irregularly placed and not articulating with corresponding teeth of the inferior dental arch. Abnormal pressure on the nerves may cause the nutrition to be arrested to such an extent as to alter the development of the teeth leading to early decay and pyorrhea alveolaris. In some cases the contour of the chest is changed and cardiac pathology produced. Obstructed respiration or defective drainage are predisposing causes of inflammation of the mucous membrane lining the nose. The inflammation may be acute or chronic.

The symptoms may be very pronounced or sub acute. Acute rhinitis in point of frequency heads the list of nasal diseases.

You are familiar with its symptoms, slight exposure or atmospheric changes, especially during the winter and spring months produces that very familiar condition "known as a cold in the head." Probably it has been so common with that member of the family, neither the parent or the doctor considers it worthy of of attention, probably the acute manifestations disappear within a few days, the child to the superficial observer is well, until another attack not unlike previous attacks appears and disappears.

Ear-ache may be added to the list of symptoms with a possible gathering in the head, but children are expected to have colds and earache, so say those who are familiar with the care of

children. Thus far nature's signals for help have not been heeded.

Defective hearing may be added to the list, also mouth breathing, and purulent nasal discharge. The wise say the child will out-grow these and call attention to the apparent lack of strength and vitality.

Time proves, the prognosis thus far offered has not been realized. Operative treatment previously advised and often urged is refused. A chronic condition may be estabished, resulting in dulled senses and loss of hearing. A reward for ignorance or the acute process may invade the brain and terminate the drama.

In conclusion, I wish to call attention to some valuable experiments made by Willis S. Anderson and his conclusions. The experiments were made upon dogs. The nostrils were artificially closed so the animal could get about one third the usual amount of air.

His observations.—Experimental Study of Nasal Obstruc tion in Dogs. (18) By Willis S. Anderson, Detroit.

Labored respiration, characteristic of asthma and emphysema; hair loses its gloss, becomes thinner, etc., skin wrinkled.

Effect upon progeny was especially interesting. Of twenty-four puppies born of mothers having one third breathing space all showed greatly reduced vitality, seventeen died within one hundred days.

Conclusion of Willis S. Anderson.

1. That Nasal Obstruction leads to death or serious impairment of vitality.
2. That the lowered resistance predisposes to infections.
3. That local disease of the respiratory tract is induced.
4. That Nasal Obstruction leads to dilatation of heart.
5. That changes in the skin and blood of the dogs occurs.
6. That symptoms resembling asthma and emphysema may be induced.
7. That emphysema of the lungs can be demonstrated histologically.
8. That reopening of the nostrils is followed by prompt disappearance of the symptoms.

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SOME THOUGHTS ON CATARRHAL PNEUMONIA.

W. G. NORMAN, M. D., Cherryvale, Kansas.

Read before the South-East Kansas Medical Society. April 12, 1910.

I have chosen this subject, not because I know more about

it than any other, nor because I have given it any special amount of study and investigation nor is it for the reason that my experience in catarrhal pneumonia has been in any way unique.

But rather for the reason that on account of an unusual, if not unprecedented epidemic of measles, our attention has been called to that subject to an unusual extent the past few months; and again, for the reason that I would like to introduce a subject, the discussion of which, might bring out practical thoughts from the experience and knowledge of the practitioners present, that will enable us to do something more effective for the little sufferers from a dreaded disease than we have done heretofore.

I do not care to discuss the pathology of the disease under consideration only in a general way, because it has very little bearing on the other points I wish to bring out; nor do I wish to speak of the etiology but to mention the variety of causes that seem to produce the disease or morbid condition we are discussing. But I do wish to emphasize the fact that the treatment of catarrhal pneumonia is altogether inadequate, that our methods are inefficient, and that the success of our treatment of the disease depends more on the providence of God than it does on the best skill we can bring to bear on the care of the little patients.

I say little patients for by far the great majority of these affected with the disease are small children; though in an epidemic of measles, such as we have had in our community this spring, some young people and even grown men and women have had the distinctive signs and symptoms of a catarrhal penumonia following an attack of measles.

Speaking of the pathology, it is probably pertinent to say that I include in the subject catarrhal pneumonia or bronchopneumonia that closely associated and always present trouble called capillary bronchiolitis. Many authors describe them as one and the same disease tho' some authors and investigators seem to make of them two distinct diseases, tho' difficult to differentiate between them, especially during early stages of the trouble.

One author states that when in a suspected case the temperature varies for from 24 to 48 hours, between 102.2. and 104.F., other conditions such as angina, exanthemata, abscess of middle ear, etc., that might cause such a temperature being excluded, the condition is almost certain to be catarrhal pneumonia instead of a capillary bronchitis. That is in my opinion, he would call the severer forms of the trouble a pneumonia, while the milder attacks, simply a bronchiolitis, symptomatically a distinction with very little difference,but as to pathological anatomy, two very

distinct affections.

Given a case of bronchial catarrh, following an attack of measles, whooping cough, influenza, diphtheria, or coming as a primary affection, in which there is a gradual rise of temperature, a tightening of the cough, a marked acceleration of pulse and respiration, perhaps a pain in the chest, a lessening of the expectoration or bronchial secretion, a distressed expression, a flushed face, perhaps a slightly cyanotic appearance of the skin and lips after a time, great restlessness, an evident effort at inhalation, dyspnoea, with dilated nares and depressions between the ribs, and the physical signs of a simple bronchial catarrh with large loose, moist, rales changing to fine, sticky, crepitant or subcrepitant rales, possibly some dullness over lower lobes on either side, or even a more tympanitic note on percussion, the fremitus probably increased, and you have a catarrhal pneumonia or capillary bronchitis, you don't know which, you know you have a very sick child, if it gets better inside of 24 to 36 hours and the temperature gets down to 100, you call it a capillary bronchitis, if the temperature stays above 102 for two days or over, you call it catarrhal or bronchopneumonia; if the child recovers you never know which it has had; if it dies and you can secure an autopsy and get a section of the diseased lung, you may be able to ascertain by minute examination, whether the inflammation was confined to the bronchioles, or whether the catarrhal inflammation extended into air cells themselves, and thus you make a correct diagnosis.

In regard to the etiology, I wish to mention that broncho penumonia, as Feer says, "is not a disease *Sui generis* as is croupous pneumonia, but is a secondary manifestation, which like the causative bronchiolitis may occur in connection with different kinds of affections" as measles, whooping cough, grip, influenza, diphtheria and any inflammatory diseases of the upper air passages.

In small children some of the worst cases I have had to treat have developed independently of any disease other than an acute cold or bronchitis.

There seems to be no specific germs that produces the disease, but a variety of micro-organisms have been found in the bronchial tubes and secretions in cases of catarrhal pneumonia, the most common being the pneumococci, pneumobacilli, staphylococci, tho' the specific germ of the accompanying disease is often found, as the diphtheria germ, influenza germ, etc. It is thought by some authors, that the disease is, in some forms, contagious.

In the handling of this disease, prophylaxis is the main thing to emphasize, for while we may prevent a good proportion of the

cases we cannot, it seems treat the disease with any great degree of success.

As the majority of fatal cases occur before the end of the third year we should advise the parents to keep the children from taking measles or whooping cough, until the child is 4 or 5 years old and keep every one suffering from a cold, influenza or sore throat, away from the babies.

And now this leads up to part of the subject I mainly wished to discuss, viz., the handling or treatment of catarrhal or bronchopneumonia and capillary bronchitis. I am almost compelled to say that in the cases I have attended, or seen in connection with other physicians, the various treatments carried out have availed very little at most, and I believe with proper hygiene, good nursing and control of the higher temperature with cool applications, proper attention to diet and little or no medication, the little patients would have fared just as well and equally as many would have recovered

This may be stating it too strongly, for I have seen some extremely sick cases, tided over with stimulants at the proper time, ultimately recover, who would probably have perished if they had not received the proper medical attention at the proper time.

I do say tho' that our most skillful, modern treatment is inadequate and that it is practically entirely symptomatic; that as great a proportion of cases recovered from the symptomatic and, I might say, voluminous treatment of our fathers as from the treatment of the most skillful specialist of today; and finally that better results might be obtained in many cases, if we did not try to do too much for them.

In studying the works of authors of about 35 to 40 years ago, we are at a loss to know just what disease or diseased conditions, they would include in our term catarrhal pneumonia. They did not use the term extensively, but described under the head of pneumonia, bronchitis with collapse of lung (atelectasis,) secondary bronchitis, or pneumonia following other diseases, just such symptoms and signs as we meet in these cases we call catarrhal pneumonia; and for that reason,—the difference in nomenclature and classification—it is hard to figure out just what proportion of the cases if catarrhal or bronchopneumonia recovered.

One author says that in 1862, Barthez stated, "that during the previous 7 years, having abandoned the use of depletion in pneumonia of children, he had treated 212 cases with a loss of but 2 patients. "This statement was taken from a work on dis-

eases of children under the section devoted to pneumonia. If the cases were all croupous pneumonia it surely is a marvelous record for any or every period of time or method of treatment.

Mergs and Pepper states, that in 65 well marked cases of lobar pneumonia, only two were fatal. They state also "that pneumonia, when it attacks children under 2 years of age it is always dangerous, more so when secondary than when primary."

I ought to say that in the cases of Barthez cited, a subsequent paragraph points out that he "takes care to eliminate the lobular or generalized pneumonias, the pseudo lobar pneumonia, the bronchopneumonias and catarrhal pneumonias, also the congestion occurring in low fevers and the secondary lobar hepatizations. Evidently, "says the authorities quoted, "the eliminations were the source of the success obtained by Barthez in his expectant or restorative methods of treatment."

The age of the little patients has had a great deal to do with the mortality of bronchopneumonia in the past as well as the present time.

Keating in 1886 said "that Meinssen lost 50% of his cases under one year of age, 40% under 3 years of age 25 over 3 years of age.

Bouchut lost 33 out of 55 under 2 years of age." These cases were evidently cases of genuine catarrhal or bronchopneumonia and is in accord with the estimates of mortality today.

"Estimates of mortality differ because of the various pathological conditions with which the disease is associated. Of 325 cases from various sources, the only qualification to be included in the list being age-under 10 years —there was a mortality of 48.3%."

Briefly, the treatment advised for that period was the cotton jacket; outward applications to be avoided; treat coughs with sedatives early, later care should be exercised in the use of opiates; expectorants advised, ipecac used as emetic early, if there is dyspnoea, later small doses as expectorant; first stage, calomel purge; later stage and in bad cases, stimulants; good food, cod liver oil and iron.

Dr. Feer of Basle, Switzerland, in a work published recently states that, "The younger the child the less is the chance of recovery, that during the first year more than ½ of the cases die."

He says, "the treatment of bronchiolitis and bronchopneumonia is practically the same." Of the numerous remedies employed, he regards the chest compress, baths, stimulants, inhalations of oxygen, and thorough moistening of the air, as the most

important. In acute cases wet compresses and luke warm baths in the beginning prove most effective.

"In high temperature cases, chest compresses at room temperature, which is kept at 66 to 68 degrees F. applied every ½ hour during the day, and in addition, luke warm baths temp. 93 to 89 is given night and morning, rubbing the skin especially the arms and legs, during the bath, fore head and face being sponged with cold water.

If discomfort, cold skin and cyanosis occur after use of compresses, use only warm bath 98 to 100. Koplik recommends baths at temp. of 105 to 106°. Renault praises hot baths for 15 minutes, twice daily, from onset of disease and claims that the pulmonary congestion is reduced thereby. Huebner recommends the mustard pack as soon as the broncholitis is diagnosed. Patients remain in pack from 10 to 30 minutes, or until he is as "red as a lobster,', then cleansed with warm water or given warm bath and kept from ½ to 2 hours in long moist pack to keep up the hyperæmia of skin, then bathed again, dried and allowed to lie quietly; this procedure carried out not more than once a day." It is said to reduce the congestion of the internal organs and therefore, the inflamed lungs.

"Fever requires no medication other than the baths, tho' quinine in small doses per rectum may be given."

"At onset of disease a vigorous expectorant may be given. In cases of failure of respiration and weakness, stimulants as camphor and caffeine may be employed. If digestion becomes disturbed, discontinue all medicine by stomach and give the camphor and caffeine hypodermically. Narcotics often act deleteriously by diminishing expectoration. For purposes of emptying the bronchi, an emetic, e. g., ipecac, is recommended, in the early stage of a violent bronchiolitis. Inhalations of oxygen, in case of severe dyspnoea, as soon as cyanosis occurs, if used freely and frequently, in cases where the bronchi are open and no extensive bronchopneumonia is present, gives good results according to some authorities. Stimulants should be given early. Beef tea, bullion, tea, coffee, as an addition to milk are to be considered first, later, caffeine and camphor, and finally in protracted cases digitalin."

"In convalesence, quinine and iron, phosphorus, and cod liver oil, in appropriate cases are to be used."

Thus I have given the therapy according to a modern authority. and thus we see that while the tendency is toward a rational therapy, it is still symptomatic and far from being effec-

tive; and while the modern treatment tends toward a greatly diminished variety of drug medication and a much more rational method of treatment from the physicians stand point, aiming at conserving the child's vitality and strength, keeping up the strength with nutriments and stimulants, using medicines mainly to counteract the worst symptoms as they arise until the child wears out the disease or vice versa. The authorities seem to advise that the physician turn over the active treatment of the case to the nurse, who must be skillful and of good judgment, to carry out intelligently the system of baths, packs, feedings, and stimulations necessary to combat the disease.

Seriously tho' we have seen, that with all the advancement in the treatment of the disease, catarrhal pneumonia, and its correlatives, capillary bronchitis, bronchiolitis, bronchopneumonia etc., about as many fatalities in proportion occur, as resulted in the days when the whole pharmacopœia was employed, in frantic endeavors, to find something that would benefit or cure the patients.

Hence, I reiterate, that prophylaxis is the thing to strive for in this disease.

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THE MEDICAL SCHOOL OF THE UNIVERSITY OF KANSAS.

MERVIN T. SUDLER, M. D., Lawrence, Kansas.

THE STATE AND PROFESSIONAL SCHOOLS.

The state of Kansas has been committed to a broad educational policy from its foundation. This is shown not only by the liberal support of common schools, but by the establishment of colleges and professional schools. For instance its School of Agriculture, Mechanic Arts, Veterinary Medicine, etc., at Manhattan; its Normal School at Emporia; and its Schools of Law, Electrical, Civil and Mining Engineering, Fine Arts, Medicine and Education at the State University at Lawrence, etc. So, the question of the state conducting professional and technical education is settled.

BEGINNINGS OF THE MEDICAL SCHOOL.

The Medical School is one of the last to be completed in organization, but it is mentioned in the constitution of the state as a part of the university. Every other profession was represented by a school when the full medical course was finally inaugurated. The beginnings of the present medical school, however, date from 1880, when the University started a preparatory course for prospective medical students. In 1889 the first two years of medi-

cal work was given. In the next few years, several attempts were made to complete the school and add the last two years to the course. Of these attempts, a plan to place the last two years work in Topkea seemed the most likely to succeed, but this finally failed.

ESTABLISHMENT OF THE FOUR YEARS COURSE.

It was not until 1905, when the University accepted a gift from Dr. Simeon B. Bell of Rosedale, of money and land to be used in connection with the medical school, that the four years course was established. At this time the University did not have sufficient funds for salaries of clinical teachers, and its resources for charity cases in its own hospitals were limited. It was therefore compelled to depend upon the men in the neighborbood of the school who would give their time as teachers, and on the hospitals which extended valuable clinical privileges to the school. Some of the teachers lived on the Missouri side of the line, and owing to the geographical position of Rosedale, the hospitals of Kansas City, Missouri were used to considerable extent. The University has been subjected to some criticism for accepting this help from Missouri. But it was the only arrangement possible, and by it, the University secured the services of many eminent men, and splendid hospital facilities, particularly, in the Kansas City General Hospital, that would otherwise not have been available for its students.

WHAT THE SCHOOL HAS ACCOMPLISHED.

Since the organization of the school in 1905, it has graduated 131 physicians. Fifty seven in 1905, twenty nine in 1907, eighteen in 1908, seven in 1909, and twenty in 1910. The entrance requirements have been raised from the high school basis to two years college work. This corresponds with the entrance requirements of the better schools of this country. The class of students which have so far enrolled in the school give every encouragement to expect the greatest success in the quality of the men that it will graduate, and the aim of the school has been to produce thoroughly trained men rather than numbers.

The work given so far has been of excellent quality. However, with the establishment of University standards for entrance, and in the first two years work, it became necessary to put the clinical work on the same basis, and this was found impractical in certain ways with the entire school located at Rosedale. So it has been found necessary to reorganize it on the broadest possible basis.

WHAT CONSTITUTES A SCHOOL OF UNIVERSITY GRADE.

Before giving the plans of this reorganization and the methods by which they were made, it may not be out of place to state briefly the standards which are demanded of a medical department of the modern University:

1. The University must control all or part of the time of its teachers in both scientific and clinical branches. This means that they must be salaried.

2. Teachers in charge of the Scientific branches of the first two years must be specialists, and devote their entire time teaching or research in their subject. This applies to Anatomy, Physiology, Bacteriology, Pathology, Chemistry, and Pharmacology.

3. The School must control the clinical facilities of its own or other hospitals as it does its laboratories for Chemistry, Biology, etc., so that accurate histories may be kept, clinical examinations made, and the student may follow all of this work in every case, from the time it enters the hospital to the time it is discharged, and not simply see an isolated operation, or patient without any relation to previous conditions, or symptoms. It can not rely on the old fashioned haphazard clinics of voluntary teachers for its instruction.

4. Good journals and literature must be provided in sufficient quantity. These together with accurate records of every clinical case, in a few years form an invaluable addition to teaching and research.

5. It must have sufficient laboratories and equipment to keep pace with the increasing demands of medical education and preventative medicine.

PLANS FOR THE FUTURE.

When an attempt was made to reorganize the school, three definite needs of the state were found to exist which had a bearing on a medical institution, and it seemed that it might be possible to combine these various medical agencies to some extent so they could be more effectively and economically administered.

The State needs:

1. A medical School by which it can supply educated physicians to its citizens, and aid in maintaining the highest standards of medical practice.

2. Laboratory work for the State Board of Health. As a great deal of this work requires the special training and equipment which are found in a good school; the teachers and laboratories could be used in the wider field of preventive medicine for the entire state as well as for teaching.

3. Aid for the medical profession of the state by provid-

ing laboratories where the more delicate and complicated examinations could be made at the minimum cost, and by providing libraries and laboratories where physicians may study or review any subject of special interest to them and by the establishment of a state hospital to take care of a portion of the charity work which should be cared for by the public, but which now is a burden to the doctor.

The university had already undertaken all the work outlined in the first paragraph. It has already been doing all of the examinations outlined in the second paragraph, except some bacteriological work. It has made some examinations for physicians as outlined in paragraph three, but it has been impossible to do much of this work on account of lack of facilities. In planning for the increase and coordination of this work, the heads of all the great schools of the country and others known as experts in medical education have been consulted. Our State Society, at Chancellor Strong's request, appointed an educational committee of five men.

To this committee, ten names were added, making fifteen in all.

The combined committee held a meeting in Lawrence in the fall, to discuss plans for the development of the school. Preliminary plans were outlined, and the most important questions embraced in these were submitted to every physician in the state by means of a circular letter. The replies received have been carefully tabulated, and are the basis for the plans now outlined.*

SUMMARY OF PLANS COMPLETED AT THE PRESENT TIME.

The plans so far approved by the Board of Regents of the University and made after this extended consultation are based upon the principles outlined before. That is, the legislature has been asked to appropriate enough money to build a hospital which the University can control. It has also been asked for money to pay salaries to the teachers in the most important clinical branches, so that the University can control their time. The legislature will also be asked to pass a bill providing for our county and city health officers sending such patients as need hospital treatment and such children as are born deformed, and liable

*The Board of Regents after carefully considering the relative advantages of Topeka, Lawrence and Kansas City decided that the latter place would give the greatest opportunity for developing a medical school of University Grade. This action was not taken until January 5th, after the accumulation of exhaustive evidence and the widest advice from the profession of the state, and medical educators of note over the country.

to become a charge to the state, to the State Hospital for free treatment; the counties or cities to bear the expense of the maintenance of such patients while they are in the hospital.

The University paid the expenses of the men invited, but the auditor limited the number to fifteen.

In order to conduct the work of the State Board of Health and the medical school more economically and efficiently, various conferences have been held between the Board of Regents and the members of the Board, and they have practically agreed upon a union of the two state functions, by making the administrative head of both departments the present secretary of the State Board of Health. The plans so far have not been completed, and it is the desire of the university to conduct a medical department of university grade, and eliminate local jealousies and personal ambitions of any particular individual, so that for this reason every phase and every proposition made has been considered with great care.

OPPOSITION TO THE SCHOOL.

In a recent interview doubt has been expressed whether there is sufficient demand for a medical school in the state to warrant its support. It has been suggested that its clinical years should be abandoned. As to the need of the medical school. The graduating class for 1910 numbered twenty, the entering class this fall, thirty, the total enrollment for the year is 83. In the medical department of Washington University at St. Louis which has recently been reorganized, and large sums of money spent in its improvement, the entering class numbers twelve. Cornell, one of the largest universities in the country, has an entering class of twenty seven. And the state University of Michigan, which for years has conducted the largest and most widely known medical school of any state university had an entering class of forty students last year.

Enrollment in the Medical Schools of the leading state Universities.

University.	1st yr.	2ndyr.	3rd yr.	4th yr.
University of Minnesota.....	49	51	37	31
University of Michigan.....	58	39	104	60
University of Iowa.....	23	26	44	23
Washington University, St. Louis	12	38	41	35
University of Kansas.....	30	18	16	19

So when we compare the population, there seems to be more demand for university medical education in this state than in the neighboring states.

OTHER SCHOOLS AND THE VETERINARY COLLEGE.

So far, the desirability and usefulness of the schools of Law, Engineering, Agriculture, or Veterinary Medicine to the state have not been questioned. In other words, as far as medicine is concerned, veterinary medicine is to be well supported and properly so. The cattle, hogs and mules of the State of Kansas will not be left without proper medical care, but its human population will get along the best it can on an accidental and weak policy of medical education without any state control, if some of the suggestions that have been made are carried out.

WILL MEDICINE BE THE ONLY PROFESSION WITHOUT A SCHOOL SUPPORTED BY THE STATE?

The legislature meeting this winter will decide by its appropriation whether the medical profession will be the only profession without any provision for training and education, in the educational system of the state, or whether it will possess a school under the control of the State University with sufficient resources to meet the demands of decent medical education. And the University cannot conduct a medical school on the old haphazard plan that has been in vogue in the proprietary schools. Only University methods as recognized by the American Medical Association and the Carnegie Foundation can be used.

Whether the legislature will act favorably on the question or not, depends on the medical profession of the state. If the profession wants such an institution then it must make this want felt throughout the state and especially through the members of the legislature representing the various counties. The advice of the entire profession has been asked in making these plans. And, in fact, the directing and controlling influence lies with it. And while the school has accomplished much in the past its future success, now depends largely on the support and approval of the profession of the state.

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Prostatic massage for gonorrheal prostatitis is not limited in its usefulness to chronic cases. In some cases of fairly acute gonorrheal prostatitis the symptoms do not abate until daily expression of the pus by massage is undertaken, and then they subside very quickly. Such a treatment must be undertaken only upon proper indications, however; otherwise employed in acute cases it will cause mischief.—American Journal Surgery.

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A malarial seizure, accompanied by vomiting and abdominal pain may simulate appendicitis, chole-cystitis, or other acute intra-abdominal lesion. A leucocytosis even of 20,000, does not gainsay the malarial diagnosis.—American Journal Surgery.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - - EDITOR.

ASSOCIATE EDITORS: J. E. SAWTELL, CHAS. S. HUFFMAN, O. P. DAVIS.

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EDITORIAL

Self-depreciation is ones own enemy.

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Calloused hands are not a badge of the "walking delegate."

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Genius does not hide herself for any great length of time.

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The successful ones early strike out of their vocabulary the word carelessness.

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While there can be no argument advanced for the poorly equipped medical school, it is amusing to look over the list of the foremost practitioners and find the school from which some of them graduated, "torn to pieces" as it were by Mr. Abraham Flexner in his Carnegie Foundation Report. It makes us stop to think, it is as much the school as is it the man?

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The Comparative Danger of Ethyl Chlorid as an Anesthetic.—Horatio C. Wood, M. D., (Journal A. M. A., Dec. 24, 1910.) comments upon the dangers of this anesthetic and says that it is 200 times as dangerous as nitrous oxid gas. He says that it should not be classed with ether on account of the anesthesia being of but a few moments duration while that of ether being much longer. However the mortality in his statistics show an average of 1 in

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15,000 for ether, to 1 in 5,710 for ethyl cholrid. He condemns it use by inexperienced and untrained persons who give it with a feeling of security (false) thinking it is much less dangerous than nitrous oxid gas. In the light of this knowledge it would seem that when a general anesthetic of a few minutes duration is required nitrous oxid gas in much safer.

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With the beginning of the New Year it is well to call the attention of the society to the Journal. To make it a success is the aim, or should be, of all the members, for it depends for its very existence upon your will. In the first place to serve its purpose the Journal should have the combined support of all, even in the smallest details. The papers read at the annual meeting as well as those from the District and County Societies of scientific interest, help to make the Journal what it is. Again reports of meetings, news notes and items of clinical interest are no small factors in supplying its columns with readable matter. Kansas is not behind in its scientific advances and it behooves us to keep outsiders informed.

Therefore with the New Year let us all pull together and open the eyes of the East as well as those of the West to the progress of medicine in Kansas.

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SOCIETY NOTES.

The Riley County Medical Society met December 8, 1910, at Dr. Littles office in Manhattan, Kansas, with the President, Dr. J. D. Colt in the chair.

Papers were read by Dr. Robert Leith, and Dr. C. B. Tepler.

The following officers were elected for the coming year.: President, Dr. J. C. Montgomery, Vice-President, Dr. B. Belle Little; Secretary Dr. J. C. Wilhoit; Treasurer, Dr. C. R. Tepler; Censor, Dr. T. R. Cave.

B. BELLE LITTLE, Secretary.

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The Montgomery county medical society met in office of Dr. Pinkston, Dec. 13, 1910.

The following officers were elected for 1911:

Dr. Geo. M. Seacat, Cherryvale, President; Dr. J. N. Strawn, Elk City, Vice-president; Dr. J. A. Pinkston, Independence, Secretary and Treasurer. After regular routine of business the doctors their wives or sweethearts, attended the Annual Banquet at Carl Leon Hotel. There were forty present.

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At the Annual meeting of the Wyandotte County Medical

Society held December 20, the following officers were elected: President, James W. May, Vice-President, L. Leverich; Secretary, J. A. Fulton, Treasurer, Anna Masterson Roberts.

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The Golden Belt Medical Society held their regular meeting at Topeka, Thursday, January 5, 1911. The following program was given: Treatment of Gonorrhoea, Dr. W. S. Yates, Junction City; Pelvic Abscess in Women, Dr. Robert Leith, Manhattan; Appendicitis, Dr. W. E. Mowery, Salina; Something About Otitis, Dr. C. L. Zugg, Kansas City.

L. O. NORDSTROM, Secretary.

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The Western Kansas and Norton Decatur Medical Societies met at Goodland, Kansas, December 15, 1910. The following program was given:

Morning Session. 10 a. m.

Embolism of the mesenteric artery, Case Report, H. O. Hardesty, Jennings, Kansas; Discussion C. S. Kenney, E. J. Beckner.

Displacements of the Uterus, E. L. Davis, Dresden, Kansas; Discussion, F. A. Carmichael, V. C. Eddy.

Afternoon Session. 1:30 p. m.

Cholecystitis, Etiology and Pathology, F. A. Smith, Goodland Kansas; Discussion, I. L. Parker, Albert Jefferies.

Cholecystitis, Diagnosis and Treatment, Wm. C. Lathrop, Norton, Kansas; Discussion N. H. Norrish, F. R. Funk.

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The Elk county medical society met at Dr. Clinton Beasley's office, Moline, Kans., November 29, 1910, for the purpose of election of officers for the ensuing year, and to transact other business of interest to society.

The old officers were re-elected for another year beginning January 1, 1911 President, J. F. Costello, Howard; Vice-Pres. J. L. Hays, Howard; Secretary and Treasurer, F. L. De Pew, Howard; Delegate to state society, G. H. Grumell, Howard.; censor, 1 year, A. J. Long, Elk Falls; 2 years F. K. Day, Longton; 3 year Burgess B. Mason, Genola.

Vernon P. Booth, Moline, was elected to membership of society.

Paper, "Reminescence of Old Time Practitioner in Old Dark County Ohio", his father being central figure, by J. L. Hayes.

Members present: Dr. A. J. Long, Elk Fall; Vernon P. Booth, Moline; J. F. Costello, J. L. Hays, W. C. Trowrbidge, G. H. Grumell and F. L. De Pew, all of Howard.

The meeting was interesting and very profitable to all present.

F. L. DE PEW, Secretary.

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NEWS NOTES

Dr. O. J. Furst of Peabody, who was president of the Kansas Medical Society 1909-10 has moved to Glendale, Calif., a suburb of Los Angeles. He will rest a year or two before he again enters the practice of medicine. He invites all the "Boys" to visit him and says the latch string will always be out for the doctors of Kansas and especially so during the next A. M. A. meeting in Los Angelus We hate to give up the doctor and wish him all the happiness possible.

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The Northwestern University Medical School, Chicago, has received a gift of $200,000 from Mr. James A. Patten, to endow a chair of medical research.

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The National Confederaton of State Medical Examining and Licensing Boards will hold its Twenty-first Annual meeting in Chicago, Ill., on Tuesday, February 28th, 1911, at the Congress Hotel.

The subjects to be taken up at this meeting will be a consideration of the state control of medical colleges; a report by a special committee on Clinical Instruction; a report on a proposed Materia Medica List by a special committee; the report on a paper presented at the St. Louis meeting, by Mr. Abraham Flexner of The Carnegie Foundation for the Advancement of Teaching; and some special papers on such subjects as the Regulation of Medical Colleges. Necessity for Establishing a National curriculum for the Medical Degree, and others, by men eminently qualified to prepare papers upon such subjects.

An earnest and cordial invitation to this meeting is extended to all members of State Medical Examining and Licensing Boards, teachers in Medical schools, colleges and universities, delegates to the association of American Medical Colleges, to the Council on Medical Education of the A. M. A., and to all others interested in securing the best results in medical education.

The officers of the confederation are, Pres. C. Guernsey, M., D., 1923 Chestnut St., Philadelphia, Pa; Secretary-Treasurer George H. Matson, M. D., State House, Columbus, Ohio.

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The Northeast Kansas Medical Society will meet at Topeka,

Kansas, February 9, 1911.

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Charles Victor Haggman, M. D., of Concordia, was married November 2, to Miss Clementine Creager, of Kansas City, Mo.

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Office of Reporter, Sumner County Sunday School Association.
Caldwell, Kansas, December 20, 1910.

Dear Sir—At the 27th Annual Convention of the Sumner County Sunday School Association, held at Caldwell, Kansas, November 30th and December 1st, 1910, the following resolutions were discussed and unanimously adopted:

"Believing that a sound national physique is of greater importance than a sound national finance.

We favor the establishment of a **National Department of Public Health** and urge our representatives in Congress to vote for same.

We furthermore urge our representatives in the Kansas Legislature to support the 'vital statistics bill' and the 'antituberculosis appropriation', and all other measures which will continue the good work of the State Board of Health and thus increases the physical welfare of the people of this great state."

Trusting to have your assurance of your hearty cooperation and support, I am, Respectfully yours,

REV. J. A. BARTHOLOMEW, Reporter.

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Office of Counsellor Sixth District, Kansas Medical Society.
Wichita, Kansas, December 20, 1910.

Dear Sir—At a meeting of the physicians of the Sixth Counsellor District of the Kansas Medical Society, embracing the counties of Pratt, Barbour, Kingman, Harper, Sedgwick, Sumner, Cowley, Chautauqua and Elk, said meeting being held at Wellington, Kansas on December 1st, 1910, the following resolutions met with unanimous approval and adoption:

"We, the physicians of the Sixth Counsellor District of the Kansas Medical Society assembled at the City of Wellington, December 1st, 1910, heartily endorse Senate Bill 6049 introduced by Sen. Robt. Owen of Oklahoma, February 1st, 1910. in the Senate of the U. S. "for the Establishment of a Department of Public Health and for other purposes" and recommend all of our Members of Congress from Kansas to support and vote for same. We especially call their attention to the fact that it contains no reference to 'medical practice' and will not in any measure restrict the practice of any method, 'cult' or 'pathy' in the treat-

ment of disease, notwithstanding assertions by certain individuals to the contrary, whose real opposition is undoubtedly based on financial or other selfish motives. We believe the "Prevention of Disease" to be paramount to all treatment and that in the establishment of a department to accomplish this prevention the U. S. should lead and not follow all the other Nations of the earth; and furthermore that Kansas always recognized as a leader of every good reform, shall maintain this long sustained reputation by the vote of our Members of Congress for this bill."

Counsellor for Sixth District was furthermore instructed to forward same to each Member of Congress from the State of Kansas.

Trusting we may have your cooperation and support on this measure, I remain, Very respectfully,

ARCH D. JONES, Counsellor.

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Belle Plaine, Kans., Dec. 20. 1910.

Dear Sir—As secretary of the meeting of the physicians of the Sixth Counsellor District of Kansas Medical Society, I am instructed to forward you the following resolution:

"We, the physicians of the Sixth Counsellor District Kansas Medical Society, embracing the counties of Pratt, Barbour, Kingman, Harper, Sedgwick, Sumner, Cowley, Chautauqua and Elk, at a meeting held in the City of Wellington, Thursday Dec. 1st. 1910, hereby endorse the standard 'Vital Statistics Bill' offered the Kansas Legislature of 1910, and also an 'Anti-Tuberculosis Appropriation Bill' so necessary to carry on the fight for the prevention and extermination of Tuberculosis, and recommend them to the attention and approval of the Members of the Legislature for 1911; furthermore we request all the members of the Legislature and especially those from the counties above mentioned to work and vote for these measures, and all other health measures so necessary to carry on the present good work of the Kansas State Board of Health and its assistants, the Public Health Officers."

Trusting to receive your assurance of your hearty cooperation and support, I am, Respectfully,

JOHN J. SIPPY, Secretary.

The above is a copy of the letter mailed to every Member of the Legislature of Kansas.—Editor.

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At the Annual Banquet of the Academy of Medicine, held in Kansas City, Mo., January 12, 1911, Dr. Joseph Collins of New

York was guest of honor.

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The American Proctologic Society's Prize for the Best Original Essay on Any Disease of the Colon by a Graduate of (not a Fellow of the Society), or a Senior Student in any Medical College of the United States or Canada.

The American Proctologic Society announces through its committee that the cash sum of $100, will be awarded, as soon as possible in 1911, to the author of the best original essay on any disease of the colon in competition for the above prize.

Essays must be submitted, to the secretary of the committee, on or before May 10, 1911. The address of the Secretary is given below, to whom all communicatons should be addressed.

Each essay must be typewritten, **designated by a motto or device, and without signature or any other indication of its authorship, and be accompanied by a separate sealed envelope, having on its outside only the motto or device contained on the essay, and within the name, the motto or device used on the essay, and, the address of the author. No envelope will be opened except that which accompanies the successful essay.**

The committee will return the unsuccessful essays, if reclaimed by their writers within six months, provided return postage accompanies the application.

The committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

The competition is open to graduates of medicine, (not fellows of the society), and to members of the senior classes of all colleges in the United States or Canada.

The object of the prize and competition is to stimulate an increased interest in, and knowledge of Proctology.

The committee shall have full control of awarding the prize and the publication of the prize essay, and it shall be the property of the American Proctologic Society. It may be published in the Transactions of the Society and also as a separate issue if deemed expedient. The committee may increase its membership if deemed advisable.

DR. DWIGHT H. MURRAY, Chairman,
DR. LEWIS H. ADLER, Jr., Secretary, 1610 Arch St., Philadelphia, Pa.
DR. SAMUEL T. EARLE, DR. JEROME M. LYNCH,
DR. LEWIS H. ADLER, Jr., Secretary, 1610 Arch St., Philadelphia, Pa.
DR. ALOIS B. GRAHAM,

Communications.

Burr Oak Kansas,, 12-5, 1910.

Editor Kansas Medical Journal, Kansas City, Kans:

Dear Doctor—I inclose a city ordinance, it is intended to shut out a lot of fakers that go from town to town and work on the credulity of the public and are a disgrace to the profession. The next advertising doctor that lands here will have a chance to test it. Our county has been cursed with them of late, and I believe we will keep them out of this town in the future.

Yours truly, J. E. HAWLEY, M. D.

(Published in the Burr Oak Herald, December 1st, 1910.)

Ordinance No. 155.

Relating to License for Transient Merchants, Traveling Doctors, Opticians and Itinerant vendors of medicines, and other things competing with the business in the City limits, Be it ordained by the Mayor and Councilmen of the City of Burr Oak, Kansas,

Section One.—That it shall be unlawful for any person, persons, Corporation or Company, Itinerant Venders ofMedicine, Optician or Traveling Doctor to come into the corporate limits of the City of Burr Oak, Kansas, and occupy any building or part with another for the purpose of temporarily vending anything or practising their profession without first paying a license therefor.

Section Two.—That the license for such Person, Persons, Corporation or Company shall be twenty-five (25.00) dollars per day for every day such person, persons, Corporation or Company shall do business within the Corporate limits of the City of Burr Oak, Kansas.

Section Three.—That the manner of paying such license shall be as follows, any person, persons, corporation or company desiring to vend or practice anything within the corporate limits of said City of Burr Oak, Kansas, shall apply to the City Clerk therefor and pay to such clerk the license fee, together with the Clerk's fee as now provided by ordinance at which time the City Clerk shall issue the required license sealed with the City Seal and deliver the same to the purchaser.

Section Four.—That any person, persons, corporation or company, traveling physician or optician violating any section of this ordinance shall be fined in a sum of not less than twenty-five dollars nor more than one hundred dollars.

Section Five.—That this Ordinance shall be in force and

take effect immediately on and after its publication in the Burr Oak Herald.

J. E. HAWLEY, Mayor.

Passed November 29th, 1910. Approved November 30th, 1910.

(Seal) Attest: J. W. GREEN, City Clerk.

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Obituary.

Jett Theodore Keith, M. D., Keokuk (Iowa) Medical College, 1901; died at his home in Wichita, Kan., November 30, aged 36.

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William B. Hardy, M. D., Jefferson Medical College, 1856; died at his home in Belleville, Kan., December 6, aged 78.

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Sarah Grattles Hiatt (license, Kansas, 1870; Texas, 1892); of Mound City, Kan; died at the home of her niece in Kansas City, Mo., November 2, from peritonitis, aged 72.

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Samuel E. Martin, M. D., Electic Medical Institute, Cincinnati; 1852; a pioneer practitioner of Kansas; surgeon of the Fifteenth Kansas Volunteer Infantry during the Civil War; died suddenly at his home in Topeka, December 8, from heart disease, aged 84.

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MISCELLANEOUS

In a hunting magazine a few weeks ago, the following amusing advertisement appeared: "Opportunity to hunt a good stag is offered to a well-known authority in diseases of women. As compensation it is required to make a correct diagnosis of the case of my wife during his stay at the hunting lodge." It is not known whether he has found a gynecologist to undertake the task.—Berlin Letter Journal, A. M. A.

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Life, in a recent issue, had the picture of an experimental physiologist being stoned by an ignorant and brutal mob, issuing apparently from the back door of the infernal regions. The cartoon is deservedly severe on the mushy and disingenuous antis, but it apparently represents a remarkable change of viewpoint on the part of the publication.—N. Y. Medical Journal.

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A distinguished teacher of medical jurisprudence reminds us that "life begins with conception, and is established with the

first fetal movement." In other words, viability is known to doctors and to mothers by the first "kick." We have frequently noted the same biologic phenomenon in our editorial experience. Often we are given to wondering whether our subscribers really read the things that we print in our journal, or whether our arduous efforts are wasted upon a clientele of dead ones. Then we happen to publish something that treads on someone's toes, or rubs someone's fur the wrong way, and we promptly elicit the sign of viability—a kick. Whereat we rub our hands and grin gleefully and take a fresh hold—not because we have hurt someone's feelings but because we realize that our readers are alive.—Medical Standard.

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Wanted.—A physician of good habits and energetic, desires a Kansas location, able to do up to date work in eye, ear ,nose and throat field. Has done considerable major surgery. Prefers to assist a busy doctor until ability has been demonstrated.

Dr. Z.—%Journal.

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Speed, Boldness and Brilliancy in Operating.—Visitors in surgical clinics are sometimes carried away by the speed and boldness with which some operations has been conducted. Their enthusiasm is often well founded, but occasionally it is furnished chiefly by the distance of the gallery from the operating table, which prevents the display of those errors of technic or judgment that have made the speed possible. If the admiring visitors learned how often the patients of some brilliantly speedy operators suffered with secondary hemorrhage, avoidable infection, disability from injury to important structures or relapses from incomplete operation, their "bold" surgeons would more properly come to be known as "bold bad" surgeons.

Speed without hurry is the accomplishment of the skilled technician who knows what he wants to do and knows how he wants to do it. Boldness is the quality of him who appreciates no less the limits to which he may safely go than the extent to which his individual handicraft can carry him. Brilliancy is the combination of these factors with originality, with the capacity to match quick wits against unexpected conditions and to fit physiological principles into pathological emergencies. Speed, boldness and brilliancy are the disiderata of all operators—the possessions of a few masters. They are factors in the saving of individual lives in the development of new surgical fields. But when speed is mere hurry, when boldness disregards anatomy and flouts surgical

principles, when brilliancy is but the quick move to cover errors of judgment, commend your body to rather the surgeon who is painstaking and deliberate, whose work is not "showy" in the the operating room—nor on the autopsy table!—W. M. B.—Editorial American Journal Surgery.

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Radium for England.—Mr. Alton, director of the English Radium Institute, has bought from the Austrian Ministry 1 gm. of radium for $75,000. This purchase was made on behalf of the well-known Jewish philanthropist, Sir Ernest Cassel, who will present it to the institute. According to the eminent scientist, Sir William Ramsey, a gram of radium is a fifth of the entire quantity in the world. In a previous letter (The Journal Nov. 5, 1910, p. 1658) an important discovery of pitchblende in Cornwall mines, which promise to be an even better source of supply than the Austrian, was announced. It is evident that the Radium Institute, which will soon be opened, will be well supplied with the precious metal.—Journal A. M. A.

At the above price it will probably be some "moons" before we will be carrying an ounce or two around in our vest pockets.—Editor.

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General Sherman's Observations Concerning Colds.—A wholesale illutrasion of the effect of outdoor living in preventing colds is contained in a letter of General Sherman to his wife written from Goldboro, North Carolina, during the Atlanta campaign. He speaks of his men, after having passed through the rigors and exposures of that strenuous campaign, and after being equipped with new clothing, as a fine-looking set of soldiers, brawny, strong and swarthy, a contrast to the weak and sickly-looking men who came to him in Kentucky three years before. He observes: "It is a general truth that men exposed to the elements do not catch cold, and I have not heard a man cough or a sneeze for three months; but were these men to go into houses, in a month the doctors would have half of them. Now the doctors have no employment." A writer in the Dietetic and Hygienic Gazette refers to this as a "symptomatic observation worthy of a doctor, but unexpected in so great a general." He says that the general was not making a holiday health speech, but writing a universal cold-cure recipe, for a remedy which is as free as air and as bounteous as the canopy over us, and which any one can procure and use.—Editorial Journal A. M. A.

CLINICAL NOTES

Ocular Chancre.—Chancres of the eyelids may be palpebral or conjunctival. A chancre situated on the ciliary border of the eyelid may be mistaken for a stye. Conjunctival chancre is more often situated on the palpebral than on the ocular conjunctiva, and generally causes conjunctivitis, chemosis, and eversion of the eyelid. Chancres situated at the outer angle of the eye cause enlargement of the preauricular gland; chancres of the inner angle of the eye cause enlargement of the submaxillary glands.—C. F. Marshall, in the Practitioner.

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Dyspnea in Pleurisy.—Dyspnea is a very characteristic symptom of pleurisy. It is most urgent in those cases in which the exudation occurs most rapidly and it is astonishing the amount of fluid which a pleural cavity may contain without causing much distress of breathing, provided that it takes place gradually. There must, however, be some other explanation than the mere slowness of the exudation, as there are cases in which, even in spite of rapid effusion, the breathing remains unembarassed. These cases give less anxiety, as the presence of urgent dyspnea is always a grave indication. F. de H. Hall, in the Practitioner.

A convenient and at the same time effective method of treatment of erysipelas is to paint the diseased area with a 25 per cent solution of ichthyol in collodion and a girdle of mercurial plaster about an inch wide applied around the patch. This application will stay on better than other solutions and at the same time is very effective.—Medical Review.

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In order to prevent subsequent deformity in palmer abscess the palm should be opened freely and immediately after the diagnosis is made. A general anesthetic is necessary as the dissection should be through, and as the palmar arch crosses on a level with the lower border of the outstretched thumb and has to be carefully avoided, makes a general anesthetic and the use of a tourniquet an absolute necessity.

Make your incision a longitudinal one—the length of the entire palm is necessary.

The after-treatment is almost as important as is the operative. Passive and later active movements should be started just as soon as the suppurative process begins to subside and granulations begin, otherwise contractions and possible ankylosis will result.

Absolute rest in bed, voluminous bandage, wet dressings

and light but nutritious diet are all valuable adjuncts, especially the rest in bed during the active symptoms.—Medical Review.

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The Diagnosis of Twin Pregnancy.—Zentralblatt fur Gynakologie, No. 40, 1910, p. 1281.)(There is no lack of signs says an editorial writer in the Lancet which may indicate the presence of a twin fœtation; it is their certain recognition which is so often difficult. The finding of two bags of membranes, the existence of a furrow between the two fœtuses, the presence of too many small or large fœtal parts, the large size of the abdomen, the apparently excessive length of the fœtal axis, and the auscultation of two hearts beating at different rates, while all valuable diagnostic aids, may not be present or their significance may be misunderstood. The diagnosis of a twin pregnancy before labour sets in is a matter of no little importance to the mother and cannot fail to bring credit to the medical attendant. In spite of this, in a very large percentage of the cases the condition is overlooked and any addition to our knowledge therefore which will prevent such mistakes in future is to be welcomed. Dr. C. J. Gauss believes that he has discovered a sign of considerable importance in this connection, and in a paper recently published in the Zentralblatt fur Gynakologie lays stress upon the presence of an anterior parietal presentation in the case of the first of twins when it is presenting by the head, as a point of considerable diagnostic value. As a result of the small size of the head and of the leverage action produced by the second child upon the body of the first, due to the want of space in utero, he maintains that this presentation is to be met with in so large a proportion of twin pregnancies as to render it of great value. In several cases where the diagnosis had proved impossible by the abdomen the presence of such a presentation has led him to the successful recognition of a twin pregnancy. An anterior parietal presentation, corresponding as it does to a marked degree of Naegele's obliquity and associated with abnormally easy recognition of the anterior ear, occurs so frequently in a normal pelvis as to render its occurrence in such conditions most suggestive of a twin pregnancy. This sign has the drawback that it is not available until labour has commenced, and it is, of course, only present when the first child presents by the head, but such a presentation occurs in some 70 to 80 per cent. of all twin pregnancies. It should therefore, if further observations tend to show that it is as constant an occurrence as Dr. Gauss supposes, prove of considerable value in helping to make a diagnosis in doubtful cases of multiple pregnan-

cy. The question is well worth further investigation, and in our opinion this physical sign has only one drawback—namely, it involves for its recognition the necessity for making a vaginal examination, whereas most of the other signs of multiple pregnancy can be recognized when present before the onset of labour and by examination of the adbomen only.—American Medicine.

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Whooping Cough Treated by Fluoroform.—Dr. Mathilde de Biehler, in Arch. de med. des enf., July, 1910, gives the results of the observation of 232 cases of whooping-cough treated with fluoroform with success. The author claims for this medication that it shortens the attack by some weeks, and renders the attacks of cough less frequent and less severe. Of the patients, 185 were seen at the beginning of the disease, and 117 at the end of two or three weeks. In thirty-eight cases treated from the beginning, in families in which there were already other cases, a cure was obtained in ten to fifteen days. In 186, cure was obtained in three or four weeks; in eight, at the end of seven to eight weeks. In these cases the number of attacks of coughing was much decreased. In eighteen cases there were complications. There were four deaths, two from pneumonia, with meningitis in very young infants, when treatment was not begun until several weeks had passed. The author observed no sublingual ulcers, vomiting, or hemorrhage. Fluoroform is a drug that merits the attention of the practitioner; it is not poisonous, even in large doses, and is well borne by even the smallest children. The author thinks it quite possible that it will prevent the disease, as well as modify its severity. In the case of a woman in danger of abortion from whooping-cough the use of the drug stopped the vomiting and lessened the cough so that the pregnancy went on to term, and the infant was delivered normally. By examining the blood of the little patient it was seen that the leukocytosis that always occurs in this disease began to diminish as soon as the drug was used. The dose of the solution should begin at ten to fifteen drops three times a day and after each attack five to ten drops, up to 200 to 250 per day. It should be increased until the desired effect is obtained.—Journal New Jersey Med. Ass'n.

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The fact that the right kidney is movable and palpable over its entire extent in over 30 per cent. of women who present themselves for general examination (Bevan), should be always considered before attributing any obscure symptoms that may exist to this condition.—International Journal Surgery.

To Promote Granulation in Wounds.—Dr. M. Baruch (Munch. med. Wochensch., No. 35, 1910) reports from Bier's clinic that the following powder has given excellent results in stimulating granulation in wounds and ulcers: Silver nitrate 1.0 kaolin, sterilized, up to 100.0, thoroughly triturated and dispensed in black bottles. Unhealthy wounds covered with pus and fibrinous exudation cleared up with remarkable rapidity, even within one or two days. Necrotic areas rapidly separated, with active production of red, healthy granulations and speedy cicatrization. The effects were particularly striking in cases of burns. The fact that the powder can be applied to infected and dirty wound surfaces is considered by the author as a special advantage over scarlet red ointment. Change of dressings depends upon the amount of secretion, which is generally greatly increased during the first few days. At the beginning the parts are dressed every second day, and later every third or fourth day.—International Journal Surgery.

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Air Embolism.—This subject, in former years one of vivid interest in laboratory investigation and appearing much in the literature of the time, is now rarely discussed, nor is it seriously dreaded as a complication of operation. The last words on the subject seem to have been contributed by Senn and Hare, the experimental investigation of the latter apparently covering the ground. It was shown by him that small quantities of air entering the veins usually are innocuous; that large quantities usually are rapidly fatal; that the quantity necessary to produce death varies enormously, both in the same species and in the individual. Also, death will be found to be due to cardiac insufficiency, brought about by mechanical causes and respiratory failure. Entering the right ventricle air interferes with the closure of the valve and allows the churning to and fro of a bloody froth. Moreover, there is a distinct impairment in the muscular force of the heart as a pump.—Therapeutic Gazette.

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It is stated that the application of the tincture of blood-root to surfaces poisoned with ivy will immediately relieve the itching and burning, and will quickly cure. And so will alcohol, we may add. Is it not the alcohol in the tincture that accomplishes the result and not the sanguinaria? At all events, the result is the same, and the former is cleaner.---American Journal Dermatology.